Memorandum

Date JAN 27 2000

From for June Gibbs Brown
Inspector General

Subject Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent Among Managed Care Organizations (A-14-98-00210)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent Among Managed Care Organizations." The purpose of this review was to compare the administrative cost amounts on the adjusted community rate (ACR) proposal among managed care organizations (MCO). This review focused on the reasonableness of the administrative costs reflected on the ACR proposal among 232 risk-based MCOs for years 1996 through 1999. To determine reasonableness, we compared each MCO's administrative costs on the ACR proposals to all plans' ACR proposals. This review is part of a series of Office of Inspector General (OIG) reviews examining the amounts of administrative costs associated with plans that contract with the Medicare program on a risk basis.

Our review of the administrative cost amounts recorded by the 232 risk-based MCOs on their ACR proposals disclosed significant disparities between plans. For example, during the 1999 ACR year, the average amount allocated by an MCO for administration ranged from a high of 32 percent to a low of 3 percent. These disparities were noted in every year of our review regardless of plan model (group, individual practice association, or staff) or tax status (profit or non-profit). Current criteria allows MCOs to allocate administrative costs on their ACR proposals based on the calculations used for the premiums charged to non-Medicare enrollees. This criteria allows MCOs to calculate rates with virtually no limits and only requires that costs (including administrative costs) be consistent with the MCOs' private lines of business.

We recommended that the Health Care Financing Administration (HCFA) seek legislation that would allow it to institute a ceiling on the amount of administrative costs that an MCO would be permitted to reflect on their ACR proposal. We suggested establishing an administrative rate ceiling of 15 percent of total revenue requirements. The 15 percent was suggested because it represented the average (administrative ACR to total ACR) rate noted during the period of review (1996 to 1999). We believe a ceiling would result in beneficiaries being offered either more benefits or reduced premiums, co-pays, etc. The

result will ultimately depend on the decision of each individual MCO. The only exception for the administrative rate ceiling would be for new MCOs that would incur additional administrative start-up costs. The exception for new MCOs should not exceed the first 2 years of operation. Using 1998 data, if a 15 percent ceiling had been applied to the ACR proposals we reviewed, an additional $1 billion in the form of additional benefits or reduced payments (e.g., deductibles and/or co-insurance) may have been passed on to the beneficiaries.

At a minimum, HCFA should aggressively review any administrative rate greater than 15 percent and require MCOs to justify the excessive administrative amounts. This is similar to how HCFA negotiates its contracts with the peer review organizations (PRO) in which HCFA determines a reasonable cost for the administrative cost component of the contract. These reasonable costs are developed based upon the PRO's historical costs coupled with the scope of the work to be performed. Any costs that exceed the reasonable limit that was established by more than 10 percent require an explanation by the contractor and this explanation is subject to HCFA's review.

In response to our draft audit report, HCFA agreed that a more thorough analysis of the ACR proposals should be performed. However, HCFA did not concur with our recommendation of setting a ceiling on administrative costs recorded on the ACR proposal. The HCFA stated that plans are now required (starting with contract year 2000) to follow a new methodology for the completion of their ACR proposals, and that an analysis of the results from the newer ACR proposals should be done before recommending any limiting requirements for the plans. The HCFA also stated that model types vary among the plans and lend themselves to higher administrative costs (i.e., staff models). In addition, HCFA was concerned that a ceiling on the administrative costs may also discourage plans from developing cost efficient plans.

This review, similar OIG reviews, and other studies have shown that MCOs exorbitant administrative costs have been problematic and can be the source for abusive behavior. For example, Malcolm K. Sparrow, the author of License To Steal, references a report by the National Association of Medicaid Fraud Control Units which cites exorbitant administrative fees as a behavior that can be destructive of adequate medical care. Therefore, we believe that HCFA should be more proactive rather than reactive in addressing issues related to administrative costs. We still believe that HCFA should seek a legislative cap on administrative costs. We agree with HCFA that an analysis should be performed on data received from the new ACR proposals. However, HCFA should develop a data base of the plans' administrative costs and any that are significantly higher than the average should be considered a candidate for further review. Effective, for contract year 2000, HCFA is required to have one-third of the plans' ACR proposals audited. Plans with higher administrative costs could be selected for audit.

Regarding the HCFA statement concerning the variation of administrative costs by model type, our analysis showed that the ranges of administrative costs all appeared similar regardless of model type as evidenced by Appendix A. Finally, we disagree with HCFA's comment that a ceiling may discourage MCO's from developing a cost efficient system. This final report has been modified to address comments made by HCFA to our draft report. The complete text of HCFA's comments are attached in Appendix C.

We would also appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-14-98-00210 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADMINISTRATIVE COSTS REFLECTED ON THE ADJUSTED COMMUNITY RATE PROPOSALS ARE INCONSISTENT AMONG MANAGED CARE ORGANIZATIONS

JUNE GIBBS BROWN
Inspector General

JANUARY 2000
A-14-98-00210

Memorandum

Date JAN 27 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent Among Managed Care Organizations (A-14-98-00210)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report analyzes the reasonableness of the administrative costs reflected on the adjusted community rate (ACR) proposal among 232 risk-based managed care organizations (MCO) for the years 1996 through 1999. To determine reasonableness, we compared each MCO's administrative costs on the ACR proposals to all plans' ACR proposals. Our review only included "mature" risk-based Medicare managed care plans[1] and analyzed administrative cost amounts to the total amount of premium charged to the plan's enrollees. This review is part of a series of Office of Inspector General (OIG) reviews examining the amounts of administrative costs associated with plans that contract with the Medicare program on a risk basis.

Our review of the administrative cost amounts recorded by 232 risk-based MCOs on their 1996 through 1999 ACR proposals disclosed significant disparities among plans. For example, during the 1999 ACR year, the amount allocated for administration ranged from a high of 32 percent to a low of 3 percent. Another way of expressing these findings is that one MCO planned to spend 32 cents out of every Medicare premium dollar for administration while another plan would spend 3 cents. Similar disparities were noted in every year of our review. Current criteria allows MCOs to allocate administrative costs on their ACR proposals at widely varying rates with virtually no limits. The Medicare Health Maintenance Organization (HMO) Manual only requires that costs (including administrative costs) noted in the ACR proposal be developed in a consistent fashion with the calculations used for the premiums charged to non-Medicare enrollees.

We recommended that the Health Care Financing Administration (HCFA) seek legislation that would allow it to institute a ceiling on the amount of administrative costs that an MCO would be permitted to reflect on their ACR proposal. We suggested establishing an administrative rate ceiling of 15 percent of total revenue requirements. The 15 percent was suggested because it represented the average (administrative ACR to total ACR) rate noted

[1]We define "mature" plans as having at least 2 years of experience as an MCO. Plans with 2 years or less of MCO experience may incur higher administrative costs. The majority of the plans in our review met this criteria during 1996, while all the plans met this criteria by 1998.

during the period of review (1996 to 1999). We believe a ceiling would result in beneficiaries being offered either more benefits or reduced premiums, co-pays, etc. The result will ultimately depend on the decision of each individual MCO. The only exception for the administrative rate ceiling would be for new MCOs that would incur additional administrative start-up costs. The exception for new MCOs should not exceed the first 2 years of operation. Using 1998 data, if a 15 percent ceiling had been applied to the ACR proposals we reviewed, an additional $1 billion in the form of additional benefits or reduced payments (e.g., deductibles and/or co-insurance) may have been passed on to the beneficiaries.

At a minimum, HCFA should aggressively review any administrative rate greater than 15 percent and require MCOs to justify the excessive administrative amounts. This is similar to how HCFA negotiates its contracts with the peer review organizations (PRO) in which HCFA determines a reasonable cost for the administrative cost component of the contract. These reasonable costs are developed based upon the PRO's historical costs coupled with the scope of the work to be performed. Any costs that exceed the reasonable limit that was established by more than 10 percent require an explanation by the contractor and this explanation is subject to HCFA's review.

In response to our draft audit report, HCFA agreed that a more thorough analysis of the ACR proposals should be performed. However, HCFA did not concur with our recommendation of setting a ceiling on administrative costs recorded on the ACR proposal. The HCFA stated that plans are now required (starting with contract year 2000) to follow a new methodology for the completion of their ACR proposals, and that an analysis of the results from the newer ACR proposals should be done before recommending any limiting requirements for the plans. The HCFA also stated that model types vary among the plans and lend themselves to higher administrative costs (i.e., staff models). In addition, HCFA was concerned that a ceiling on the administrative costs may also discourage plans from developing cost efficient plans.

This review, similar OIG reviews, and other studies have shown that MCOs exorbitant administrative costs have been problematic and can be the source for abusive behavior. We believe that HCFA should be more proactive rather than reactive when addressing issues related to administrative costs. We still believe that HCFA should seek a legislative cap on administrative costs. We agree with HCFA that an analysis should be performed on data received from the new ACR proposals. However, HCFA should develop a data base of the plans' administrative costs and any that are significantly higher than the average should be considered a candidate for further review. Effective, for contract year 2000, HCFA is required to have one-third of the plans' ACR proposals audited. Plans with higher administrative costs could be selected for audit.

Regarding the HCFA statement concerning the variation of administrative costs by model type, our analysis showed that the ranges of administrative costs all appeared similar

regardless of model type as evidenced by Appendix A. Finally, we disagree with HCFA's comment that a ceiling may discourage MCO's from developing a cost efficient system. This final report has been modified to address comments made by HCFA to our draft report. The complete text of HCFA's comments are attached in Appendix C.

INTRODUCTION

BACKGROUND

Managed care plans provide comprehensive health services on a prepayment basis to enrolled individuals. Medicare beneficiaries have the option to enroll in MCOs which contract with HCFA to furnish all medically necessary services covered under the Medicare program. Legislation allowed Medicare to contract with managed care organizations since 1972.

The major Medicare managed care program, the Medicare risk contract program, dates back to 1982 when the Congress enacted the Tax Equity and Fiscal Responsibility Act. This legislation was implemented in 1985 and gave Medicare enrollees the option to enroll in risk-based MCOs. Under the Medicare risk-based program, MCOs must assume responsibility for providing all Medicare-covered services in return for a predetermined capitated payment.

As of September 1998, approximately 75 percent of the Medicare managed care plans were risk-based plans. Additionally, from 1993 to 1998 beneficiary enrollment in risk-based plans has almost tripled to approximately 5.9 million beneficiaries. In 1998, risk-based plans received $30.6 billion in Medicare payments. The Congressional Budget Office expects these payments to quadruple over the next 11 years to $141 billion by the year 2009.

THE ACR PROPOSAL

Organizations with a risk-based contract are required to submit an ACR proposal to HCFA prior to the beginning of the contract period. The ACR process is designed for MCOs to present to HCFA their estimate of the funds needed to cover the costs (both medical and administrative) of providing a Medicare package of covered services to an enrolled Medicare beneficiary. The ACR calculation includes a development of administrative and medical costs. Administrative costs are the non-medical costs of compensation, interest, occupancy, depreciation, marketing, reinsurance, and other costs incurred for the general management and administration of the business unit as well as profit or loss. During the period of review the ACR calculation was as follows:

- A base rate was first developed. This rate was the average premium rate the MCO will charge its non-Medicare enrollees during the contract period on a per member per month (PMPM) basis. A base rate was developed for various categories of medical services (e.g., inpatient hospital, skilled nursing, physician, laboratory, hospital outpatient, etc.) and administration.

- The plan then adjusted each category in the base rate to eliminate the value of those services not covered by Medicare. The plan also made adjustments to include the value of covered Medicare services that were not in the base rate. The result of these adjustments was the initial rate. The initial rate was the rate the plan would have charged its commercial members if the commercial package was limited to Medicare coverage.

- The next step in the process was to multiply the initial rate by utilization factors to reflect the differences in the volume, intensity, and complexity of services used by Medicare members in comparison to non-Medicare members.[2]

The result of the above steps reflects what the plan estimates its revenue requirements will be to furnish the Medicare covered services benefit package. The purpose of the ACR is to ensure that Medicare beneficiaries are not overcharged for the benefit package offered. After calculating their ACR, the plans compare the ACR to their projected average payment rate (APR). The APR is the amount of Medicare revenue the MCO expects to receive during the period covered by the ACR proposal on a PMPM basis. If the ACR is less than the APR (in effect, an MCO would compare their budgeted estimated costs to their estimated Medicare revenues), a savings is noted. Any savings noted in the ACR proposal are passed through to the beneficiary in any of the following ways: a noncovered Medicare benefit, a reduction in the Medicare enrollee's MCO premium or co-insurance, or a contribution to a benefit stabilization fund.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review focused on the reasonableness of the administrative costs reflected on the ACR proposal among 232 risk-based MCOs for the years 1996 through 1999. To determine reasonableness, we compared each MCO's administrative costs on the ACR proposals to all plans' ACR proposals. Our analysis only included risk plans that were in existence for all 4 years our review encompassed. This represented the majority of risk plans for this period.

To achieve our objective, we divided a plan's administrative ACR by the total ACR (both rates were reflected on the ACR proposal) to obtain a percentage of administrative costs to total costs. We then compared this percentage among the different plans.

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[2]The development of the ACR for the 2000 calender year has been revised as a result of the Balanced Budget Act of 1997. One major change eliminated the use of utilization factors, instead relative cost ratios (actual medicare costs compared to non-medicare costs) will be substituted.

We categorized the plans according to their appropriate classification such as: individual practice associations (IPA), staff, or group model; and profit and nonprofit tax status to further determine consistency within common classifications.

This limited scope review was performed in accordance with generally accepted government auditing standards and was concluded in Fiscal Year 1999.

FINDINGS AND RECOMMENDATIONS

Our review of the administrative cost amounts recorded by 232 risk-based MCOs on their 1996 through 1999 ACR proposals disclosed significant disparities between plans. For example, during the 1999 ACR year, the average amount allocated for administration ranged from a high of 32 percent to a low of 3 percent. Current criteria allow MCOs to allocate administrative costs on their ACR proposals based on the calculations used for the premiums charged to non-Medicare enrollees. This criteria allows MCOs to calculate rates with virtually no limits and only requires that costs (including administrative costs) be consistent with the MCOs' private lines of business.

Unlike other areas of the Medicare program, a reasonable percentage or ceiling for an administrative cost rate on the ACR proposals is not required by HCFA. For example, when negotiating PRO contracts, any costs that exceed by more than 10 percent of a reasonable limit established by HCFA require an explanation by the contractor that is subject to HCFA's review. Establishing a 15 percent administrative ceiling of total revenue (the 15 percent was selected because it represented the average administrative rate noted during our review) would result in beneficiaries being offered either more benefits or reduced premiums, co-pays, etc., depending on the decision of an individual MCO. Using 1998 data, if a 15 percent ceiling had been applied to the MCOs we reviewed, an additional $1 billion in the form of additional benefits or reduced payments (e.g., deductibles and/or co-insurance) may have been passed on to the beneficiaries.

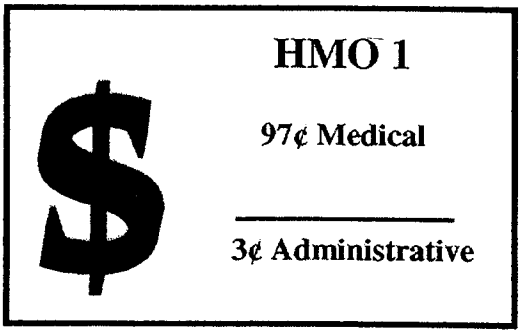
ALLOCATION OF THE ADMINISTRATION RATE

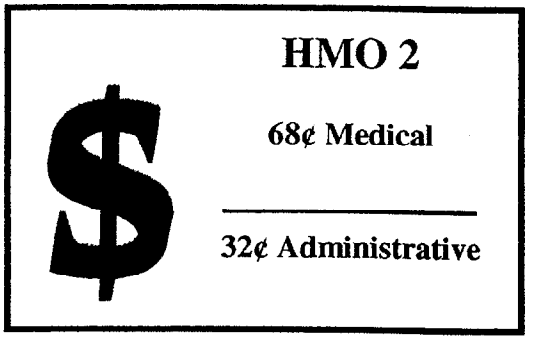
During the period of our review, HCFA criteria allowed risk-based MCOs a wide latitude in determining their administrative rates - unlike plans with Medicare cost contracts that have clearly defined criteria for claiming reimbursements for their administrative costs. For Medicare risk-based contracts, all assumptions, cost data, revenue requirements, and other elements used by MCOs in the ACR proposal calculations must only be consistent with the calculations used for the premiums charged to non-Medicare enrollees, including the administrative component. In theory, these costs should bear some relationship to actual administrative costs recorded on an MCO's financial statements. However, there are virtually no limits on the amounts an MCO can include in their ACR proposal.

Beginning with Medicare contract year 2000, the costs allocated to the Medicare line of business will be an important factor in the ACR process. The costs will determine the estimated funds needed to cover the costs of providing the package of covered services to an enrolled Medicare beneficiary. The plans will be required to use their actual Medicare costs in developing their ACR for contract year 2000 and beyond. Without HCFA instituting additional controls over the amount of administrative costs that an MCO can incur, the variations we note in this report will continue and MCOs will be able to allocate unnecessary non-medical related costs to their Medicare ACR.

VARIATION OF ADMINISTRATION RATES AMONG PLANS

We found the administrative ACRs varied widely among the MCOs regardless of the model or type (i.e., profit, nonprofit, IPA, group, staff). For example, in the 1999 ACR proposals, the average amount allocated for administration ranged from a high of 32 percent to a low of 3 percent. Another way of expressing these findings is that one MCO planned to spend 32 cents out of every Medicare premium dollar for administration while another MCO planned to spend only 3 cents of every Medicare premium dollar for administrative purposes.





Our review analyzed the amounts allocated for administration based on various factors that distinguish the types of MCOs. We compared plans based on profit, nonprofit, and model type. The results of our analysis for the 1999 ACR year are as follows:

1999 ADMINISTRATIVE RATES

	High	Low
Nonprofit	28.6%	3.4%
Profit	32.0%	5.2%
Group	29.3%	3.4%
IPA	29.5%	5.8%
Staff	32.0%	7.4%

A detailed analysis comparing the high and low percentage of the administration ACR to the total ACR is provided as Appendix A to this report. For each ACR year from 1996 through 1999, Appendix A provides a comparison by the various MCO models (staff, IPA, and group) and by tax status (profit or nonprofit). As evidenced in Appendix A, the fluctuations are significant even within similar categories. We also noted similar variations among plans when we used total enrollment size as the variant.

After conducting our initial analysis, we wanted to determine if there were any significant factors that would cause some plans to allocate less for administration while other plans allocated a considerable amount more for administration.

We reviewed MCO's annual financial data files maintained by HCFA to determine if there were any particular administrative expenses that would contribute to the wide variations among MCOs. Our review of the financial data focused on the plans that had a high percentage of administration ACR to the total ACR for 1996. The administrative expenses examined included those items of the administration component of the ACR proposal - depreciation, interest, reinsurance, compensation, marketing, other costs, and profit/loss. Based on available data, we found that the majority of the plans with an administrative rate greater than 15 percent spent a greater percent of their administrative dollars on compensation (salaries and fringe benefits for administrative personnel).

VARIATIONS WITHIN ONE GEOGRAPHIC AREA

We analyzed two HMOs to determine if geographical differences may contribute to the administrative cost fluctuations. Both HMOs operated in the same counties of a particular State and had significant Medicare and commercial enrollees. Specifically, we noted that while one plan reflected an administrative ACR to the total ACR of 4.4 percent (less than 5 cents of every Medicare premium dollar), the other plan reflected an administrative ACR to the total ACR of 22.6 percent (nearly 23 cents of every Medicare premium dollar). Considering that both plans have a similar beneficiary base, same location

and similar enrollment amounts, any difference between the administrative costs should have been minimal. This further established the fact that administrative costs should be better controlled.

SETTING A CAP ON THE ADMINISTRATION RATE

We believe that a ceiling on administrative costs reflected on the ACR proposal should be instituted. It is apparent that some plans are able to control administrative costs more effectively than other plans. Approximately $1 billion would have been available for additional benefits if HCFA had instituted a 15 percent ceiling on the amount of administrative costs that an MCO would have been permitted to reflect on their 1998 ACR proposal. The 15 percent ceiling is based on the average (administrative ACR to total ACR) rate noted during our period of review (1996 to 1999). The $1 billion was derived by taking all the plans in our review that exceeded 15 percent (administrative ACR to total ACR) for 1998 and replacing their actual percentage of administrative ACR to total ACR with 15 percent. The difference between the actual percentage and the 15 percent was multiplied by the total Medicare enrollees for 1998 to obtain an adjusted amount of additional funds that could have been available for additional benefits or reduced premiums (see Appendix B for an example of the calculation of one plan reflecting the higher percentage of administrative costs). The adjustments were added for all the MCOs to calculate the $1 billion. An administrative rate ceiling would more accurately reflect an MCO's administrative costs as these costs relate to the Medicare program. This will result in beneficiaries being offered more benefits or paying less for their insurance coverage (e.g., premiums and/or co-pays).

EXAMPLE OF THE BENEFIT OF CAPPING THE ADMINISTRATION RATE

As a further analysis of this issue, we performed a detailed review of the administrative ACR of one MCO included in our universe. Our review disclosed that based upon the MCOs documentation, the 30.7 percent administrative factor used to support the administrative ACR on their Medicare proposal was inappropriate. Our review revealed that this MCO had developed six different administrative factors based upon the number of covered members for six different strata or scenarios (see the following chart). The administrative factor reflected on the actual Medicare proposal, the highest of the 6 scenarios, was based on their estimate that the number of covered Medicare enrollees would be less than 50 beneficiaries within the MCO's total population. The lowest calculated administrative factor that could have been used in the submission to HCFA was based on the number of covered Medicare enrollees which was 2,000 or greater of the total population. This particular MCO had an average of well over 2,000 Medicare beneficiaries enrolled per month. Therefore, the lowest administrative factor (16 percent) would appear to be the more appropriate factor to use. The 16 percent administrative factor best represents the MCOs Medicare administrative ACR rather than the 30.7 percent submitted. If our suggested administrative ACR ceiling of

15 percent had been applied to this MCO for 1998, an additional amount of over $26 million would have been recognized on this MCO's ACR proposal resulting in potential additional benefits to the Medicare beneficiaries enrolled.

Number of Covered Members	Administrative Factor
1-49	30.7%
50-99	23.2%
100-499	22.8%
500-999	21.0%
1,000-1,999	19.0%
2,000 & over	16.0%

RECOMMENDATIONS

It is estimated that by the year 2009 Medicare reimbursement payments to risk-based MCOs may amount to $141 billion annually. It is critical for HCFA to ensure these reimbursements are only for proper Medicare costs, including the administrative costs required to operate these plans. With such a wide range of administrative costs currently being reflected on the ACR proposals, it is difficult to believe these estimated costs are a proper depiction of the costs some MCOs are incurring.

We recommended that HCFA perform a more thorough analysis of the ACR proposals they receive. This analysis should include a comparison among all the MCOs to determine a reasonable administrative cost rate. In this regard, we recommended that HCFA institute a ceiling on the amount of administrative costs that would be permitted on the ACR proposal by an MCO. To enable HCFA to institute a ceiling, we recommend that HCFA introduce legislation that would allow for HCFA to institute the ceiling. We suggest HCFA establish an administrative rate ceiling of 15 percent of total revenue requirements. Fifteen percent was the average percentage of all the risk-based MCOs included in our review. We noted that the administrative ACR exceeded the total ACR by more than 15 percent for 55 percent of the MCOs included in our review. A ceiling would more accurately reflect an MCO's administrative costs as these costs relate to the Medicare program and in turn result in more costs being used for medical services and less for administrative purposes. The only exception for the administrative rate ceiling would be for new MCOs that would incur additional administrative start-up costs. However, the exception for new MCOs should not exceed the first 2 years of operation.

HCFA COMMENTS

In response to our recommendations, HCFA agreed that a more thorough analysis of the ACR proposals should be performed. However, HCFA stated that since plans are now required (starting with contract year 2000) to follow a new methodology for the completion of their ACR proposals an analysis of results from the newer ACR proposals should be done before recommending any limiting requirements for the plans. The HCFA believed the new methodology would enable more accurate data to be collected and allow a better analysis. Under the new methodology, plans are required to reflect administrative costs as the actual costs incurred in treating Medicare beneficiaries. Previous methodology allowed plans to reflect administrative costs for their commercial population in order to determine Medicare administrative costs.

The HCFA did not concur with our recommendation of setting a ceiling for administrative costs recorded on the ACR proposal. The HCFA believed that since new guidelines for completing the ACR proposals are now in effect, it would be premature to determine whether a ceiling is appropriate. Furthermore, HCFA did not believe that it had the authority to place any limits on the plans regarding their administrative costs. The HCFA suggested that legislative action would be required before any such limitations could be imposed.

The HCFA also stated that the 15 percent administrative cost limit that we suggested was oversimplified. It further stated that some MCO structures or model types lend themselves to higher administrative costs (e.g., staff model MCOs historically have a higher administrative load than a typical IPA model). In addition, HCFA thought that start-up organizations will also experience higher administrative costs and should not be restricted to an administrative cost ceiling.

The HCFA was also concerned that a ceiling on the administrative costs may also discourage plans from developing cost efficient plans. This would apply to plans operating well below an administrative cost ceiling. The HCFA believed that using outdated results to develop limits may cause undue restrictions on plans that would not be justified.

The full text of HCFA's comments are included in Appendix C.

OIG RESPONSE

This review, similar OIG reviews, and other studies have shown that MCOs exorbitant administrative costs have been problematic and can be the source for abusive behavior. For example, Malcolm K. Sparrow, the author of License To Steal, references a report by the National Association of Medicaid Fraud Control Units which cites exorbitant administrative fees as a behavior that can be destructive of adequate medical care. Therefore, we believe that HCFA should be more proactive rather than reactive in addressing issues related to administrative costs.

We agree with HCFA that an analysis should be performed on data received from the new ACR proposals. However, HCFA should develop a data base of the plans' administrative costs so that additional analysis can be performed. Then, any administrative costs that are significantly higher than the average should be considered as a candidate for further review. Effective, for contract year 2000, HCFA is required to have one-third of the plans' ACR proposals audited. Plans with higher administrative costs could be selected for audit.

The HCFA stated that some administrative cost variation is expected based on model type. However, as evidenced by Appendix A, the administration rate variations are insignificant based on model type, especially when comparing staff model MCOs to IPA model MCOs. Another guideline for further review is when the administrative cost ratio exceeds a predetermined benchmark based on model type. We agree with HCFA that start-up organizations will experience higher administrative costs and should not be restricted to an administrative cost ceiling. However, any exclusion from a rate ceiling should be limited to the plan's first 2 years of operation.

Finally, we disagree with HCFA's comment that a ceiling may discourage MCO's from developing a cost efficient system. We believe if the reviews of the ACR proposals are properly taking place, a plan with low administrative costs that suddenly increases its administrative costs to take advantage of the ceiling would stand out during an analytical review. This increase should be further pursued either through an audit or normal inquiries with the plans.

HCFA TECHNICAL COMMENTS

The HCFA offered technical comments to our report that related to our description of how we computed administrative costs. The HCFA commented that premium waivers and ACR losses must be removed from the administrative component of the ACR to determine the administrative cost rate being charged to Medicare. The HCFA further stated that these premium waivers enable some of these plans to be competitive and therefore, they should be taken into account.

In addition, HCFA commented that the OIG used in Appendix B the total enrollment of all plans which overestimated the impact of the recommendation.

OIG RESPONSE

Our calculation of the administrative costs was based upon HCFA's definition of the items that are included in the ACR according to section 5203 of the HMO Manual. For the administrative component, we included the following elements: reinsurance expenses, the non-medical costs associated with the overall management and operation of the HMO, and amounts retained by the HMO as either profit or retained earnings. Operational items include: interest expense, occupancy, depreciation, amortization of the facilities, marketing,

and other administrative expenses. Our review did not examine a plan's premium waiver or ACR losses, since these amounts are computed after the computation of the medical package and the administrative cost load. The plans should not inflate administrative costs so that they could "waive" premiums. This would distort the actual cost of having a Medicare managed care program. Also, the National Data Reporting Requirements which are the financial statements completed by the plans for their state regulatory requirements do not include premium waivers in their definition of administrative costs.

Finally, the calculations in Appendix B includes only one plan as stated and not all the plans as presented by HCFA.

Where appropriate, we modified our report to reflect comments provided by HCFA.

Appendix A

COMPARISON OF ADMINISTRATION RATES
BY VARIOUS MCO CATEGORIES

1996 ACR PERIOD

	High	Low
Nonprofit	32.1%	2.5%
Profit	30.7%	3.1%
Group	24.6%	2.5%
IPA	32.1%	3.1%
Staff	30.7%	7.9%

Average 14.49% for all the plans

1997 ACR PERIOD

	High	Low
Nonprofit	32.1%	3.2%
Profit	30.7%	8.7%
Group	24.1%	3.2%
IPA	32.1%	7.8%
Staff	30.7%	8.4%

Average 14.88% for all the plans

1998 ACR PERIOD

	High	Low
Nonprofit	32.8%	3.6%
Profit	32.0%	6.4%
Group	29.3%	3.6%
IPA	32.8%	6.2%
Staff	32.0%	7.7%

Average 14.97% for all the plans

1999 ACR PERIOD

	High	Low
Nonprofit	28.6%	3.4%
Profit	32.0%	5.2%
Group	29.3%	3.4%
IPA	29.5%	5.8%
Staff	32.0%	7.4%

Average 16.49% for all the plans

Appendix B

The Effect of the 15% Cap on One Plan In Our Review With a High Administrative ACR:

	Medical ACR	***Administrative ACR***	***Total ACR***	***Administrative ACR to Total ACR***
As recorded on the ACR proposal	*396.9*	*115.59*	*512.49*	*22.55%*
With a 15% Cap	*396.9*	*70.04*	*466.94*	*15%*
Potential Savings From Cap			***45.55***	

This plan had a total of 5,300,816 Medicare member months for 1998. Multiplying this total by the potential savings of $45.55 by imposing a 15 percent cap would result in $241,452,169 being available for additional benefits or reduced payments for the Medicare beneficiaries.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 12 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent Among Managed Care Organizations," (A-14-98-00210)

Thank you for the opportunity to review and comment on the issues raised in the above-referenced draft report.

The OIG inspection focused on the reasonableness of the administrative costs reflected on the adjusted community rate (ACR) proposal among 232 risk-based managed care organizations (MCOs) for 1996 through 1999. The report found that the Health Care Financing Administration (HCFA) criteria allow risk-based MCOs a wide latitude in determining their administrative rates.

OIG recommends that HCFA perform a more thorough analysis of the ACR proposals they receive in order to establish a more reasonable administrative cost rate. OIG further recommends that HCFA institute a ceiling on the amount of administrative costs we would permit on the MCOs' ACR proposals. Specifically, OIG suggests establishing an administrative rate ceiling of 15 percent of total revenue requirements.

Our specific comments on the report recommendations follow:

OIG Recommendation
HCFA should perform a more thorough analysis of the ACR proposals they receive.

HCFA Response
We concur. In the past, the presentation of administrative costs in the ACR proposals of managed care plans has varied widely. On June 26, HCFA published a new method for determining plans' Medicare costs. This method will more accurately reflect plans' administrative costs for Medicare, thereby allowing beneficiaries to receive additional benefits from the plans, as the Balanced Budget Act of 1997 intended. The new ACR will apply to the upcoming contract year 2000.

Under the old method, Medicare plans used administrative costs in their commercial population in order to determine Medicare administrative costs. In effect, this allowed administrative costs to increase as medical costs increased, essentially treating all administrative costs as fully variable when, in fact, there are both fixed and variable administrative costs. This result will not be allowed under the new ACR. Under the new method, administrative costs for Medicare beneficiaries will be determined by using costs actually incurred in treating Medicare beneficiaries during the previous calendar year.

HCFA's intention in developing the new ACR is to collect better and more comparable information on administrative costs and additional revenues during the first year, then analyze the data before we recommend whether any new, limiting requirements are indicated. Our next step would be to solicit further input from stakeholders, e.g., industry representatives, state health insurance regulators, industry consultants, and groups representing the Medicare beneficiaries.

OIG Recommendation

HCFA should institute a ceiling on the amount of administrative costs that would be permitted on the ACR proposal by an MCO.

HCFA Response

We do not concur with the recommendation of setting an administrative rate ceiling. As explained above, we have just begun to require plans to use new guidelines when determining their administrative costs for their ACR proposals. Until plans have become more familiar with this new method and we have information on the variation in administrative costs under it, we believe it would be premature to determine that a ceiling is appropriate. Any conclusions based on the prior method may be challenged by information in the ACRs developed using the June 1999 guidelines. Any limit based on outdated information could introduce a constraint on plans' behavior that may not be justified.

Two sections of the Social Security Act, section 1876(e)(3), for risk contracting MCOs, and section 1854(f)(3), for Medicare+Choice organizations, describe the formula used to establish a Medicare ACR value for a service or group of services. These two sections describe the ACR value as the average non-Medicare price for a service or group of services of an MCO, modified by differences in utilization characteristics between the Medicare population and the non-Medicare population. We believe neither of these sections affords HCFA the discretion to place the kinds of limits on ACR values that OIG

proposes. Unlike other programs paid under Medicare, Congress has not granted HCFA discretion in the payment rules. Therefore, we believe legislation is required to implement any limitation on the amount of administrative costs reported by MCOs.

We further believe that use of a 15 percent administrative cost limit may be oversimplified. As acknowledged by OIG, there are wide variations reported by the MCOs. While we do agree there may have been some inappropriate administrative cost ratios reported on the ACRs, we strongly believe some variation is to be expected and a 15 percent administrative cost cap may be inappropriate for many organizations. Variances are to be expected based on the model type of the MCO. Staff model MCOs historically have a higher administrative load than a typical individual practice association model. A 15 percent cap on a staff model MCO could severely undermine the fiscal viability of the MCO. In establishing the 15 percent administrative cost limit, the OIG used an average of some highly variable and suspect data. We do not agree that cost limits should be developed in this manner.

Further, new start-up organizations with little or no membership will experience a higher administrative cost ratio than an organization that has been operating for a period of time. We note that the OIG report included no new organizations in its review. Only organizations that participated in the Medicare program during the period 1996 through 1999 were included. This would tend to reduce the expected administrative cost ratio. To place an administrative cost cap on a start-up organization would not allow the organization to recognize these costs at a time when there is little or no revenue stream.

We are also concerned that a 15 percent cap may further discourage MCOs from developing cost efficient systems; systems that may well reduce the administrative ratio far below the 15 percent cap. We also believe it is inappropriate to compare MCOs to other programs such as the Peer Review Organizations (PRO). Under the PRO contract, there is a specific scope of work that can identify and outline administrative costs. In MCOs, administrative costs vary widely due to the nature of not only the organization, but also the type of services being offered. Enrollment increases, marketing strategies, and competition are all factors that will increase administrative costs. Low enrollment will also increase the administrative cost ratio.

As we are still in the process of correcting the methods by which ACRs are calculated, it is premature to ascertain whether a ceiling would make sense. Conclusions based on old information may be challenged by new information. A limit, based on outdated information, would introduce a constraint on plans' behavior that may not be justified. HCFA's experience suggests that limits on administrative expenses can inappropriately constrain management of benefits.

The report also indicates that, if the suggested administrative ACR ceiling of 15 percent had been applied to the MCOs' 1998 ACR proposals, about $1 billion would have been available for additional benefits. However, under the current method, the amount of additional benefits approved by HCFA for 1998 exceeded $3 billion due to premium waivers.

Technical Comments

Page 4 - We were unable to determine the exact method OIG used to calculate MCOs' administrative cost ratios. OIG "divided a plan's administrative ACR by the total ACR (both rates were reflected on the ACR proposal) to obtain a percentage of administrative costs to total costs." The old ACR format included both administrative costs and profits within the administrative ACR. The report does not indicate whether the organization's decision to waive premiums that could have been charged on the basic package was taken into account. Premium waivers and ACR losses must be removed from the administrative component of the ACR to determine the administrative cost rate being charged to Medicare. Removing these items would tend to lessen the impact as calculated by the OIG.

Organizations in competitive areas generally do not charge as much as they would have been allowed to charge for the basic benefit package, i.e., Medicare-covered services, additional services, and mandatory supplemental services. When an MCO decided to forego collecting a premium under the old ACR format, HCFA treated this differential amount as a premium waiver displayed in a different part of the same ACR proposal. Organizations would fund these premium waivers from profits (included in the administrative ACR) that could have been charged for the basic benefit package or from other sources.

Page 7 - While it might appear that modifying the allowable administrative costs should result in more funds available for additional benefits or reduced premiums, this is not necessarily the case. Medicare managed care plans often "waive" substantial amounts of allowable beneficiary premiums. While our position is that such waivers must be funded by non-Medicare funds, we can not know that this is the case. The actual amount of money available for reduced premiums might not change in any significant way if and when allowable ACR entries for administrative costs are reduced relative to past experience.

The OIG selected its 15 percent administrative cost limit because it represented the average rate noted during their review period. An average rate indicates some organizations were above average, some may be at average, and some were below average. For those organizations that were at or below average, the OIG recommended

administrative cost limit would not be applicable and no more additional benefits could be passed on to the Medicare enrollee. However, in Appendix B, the OIG in calculating the impact of its recommendation used total enrollment of all plans which tends to overestimate the impact of its recommendation.